Texas Department of Aging
and Disability Services

Form 2700
June 2014

Application for a Treatment Decision by a Surrogate Consent Committee

To be signed by an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Provider Representative
Please type or print clearly

Department Use
_____
Case Number (to be assigned by SDM)

Facility Name		Vendor Number
Individual's Name	Date of Birth	Social Security Number

This application is made to the Texas Department of Aging and Disability Services for a Surrogate Consent Committee (SCC) hearing on behalf of:

Name (Last, First, MI)	
Home Address (Street, City, State, ZIP)	County

The consent decision requested pertains to non-emergency**: (Place an X by the appropriate choice.)**

- ☐ **Major Medical Treatment**
- ☐ **Major Dental Treatment**
- ☐ **Treatment with Psychoactive Medication**
- ☐ **Highly Restrictive Procedure**
- ☐ **Other:** _____

Note: Attach a "Certification of Need" form for the category checked above. When submitting more than one treatment application, a separate application and certification of need form are required.

The condition or disease to be treated is stated to be:

The proposed treatment is: **(List psychoactive medications and dosages and/or name and/or description of treatment.)**

The treatment is recommended by:

- ☐ **Physician or Dentist (includes Psychiatrist)**
- ☐ **Psychologist or Psychological Associate**
- ☐ **Facility Interdisciplinary Team**
- ☐ **Other Professional Consultant**

The individual or representative has been presented with the above stated information and holds the following opinion regarding the proposed treatment and the alternatives:

Source: _____

Opinion: _____

If the individual is not able to communicate an opinion or preference, state reasons:

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An assessment of the individual's capacity to make the consent regarding this treatment was conducted on _____ .
Date

The person who conducted this assessment is:

Name	Title	Employer — Facility Name

Based on this assessment, the following evidence supports a need to refer the consent decision to an SCC:

Was training or education provided to assist the individual in making the consent decision? ☐ Yes ☐ No

If yes, what indicators were present to suggest the individual would not be able to make an informed decision with continued training or education:

If no, state the reason why training or education was not provided:

The reason the proposed medication, treatment or procedure is needed and promotes the best interest of the individual is:

If the individual is below the age of 18, do they have a managing or possessory conservator? ☐ Yes ☐ No

If yes, complete the following information:

Conservator Name	Area Code and Phone Number

Address (Street, City, State, ZIP)

Does the individual have an actively involved spouse, adult child, parent, stepparent or other adult relative who is qualified to be a surrogate decision maker (SDM)? ☐ Yes ☐ No

If yes, complete the following information:

Name	Relationship to Individual	Area Code and Phone Number

Address (Street, City, State, ZIP)

If yes, to either of the above questions, what is the reason this person is not willing to provide legally recognized consent for this decision for the individual?

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List this individual's current medication, dosage and frequency of administration:

This individual's known allergies are: (include food, drug, pollen, etc.)

Send a copy of the most recent pharmacist's medication review.
Send copy of the most recent physical examination.

Describe any abnormal findings of the physical examination:

Send applicable laboratory screenings (CBC, chemistry panels, etc.) and diagnostic testing.
Send a copy of the most recent EKG, if applicable.
Send a copy of the most recent chest x-ray, if applicable.

Is there any history of cardiac disease? ☐ Yes ☐ No

If yes, describe:

Is there any history of pulmonary (lung) disease? ☐ Yes ☐ No

If yes, describe:

Is there any history of major illness and/or surgery in the last year? ☐ Yes ☐ No

If yes, describe:

Is there any history of any significant psychological stressors in the last year? ☐ Yes ☐ No

If yes, describe:

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Attached are the following documents (please check each that apply):	Form No.
☐ Certification of Need for Major Medical Treatment	2705
☐ Certification of Need for Major Dental Treatment	2710
☐ Certification of Need for Psychoactive Medication	2715
☐ Certification of Need for a Highly Restrictive Procedure	2720
☐ List of Persons to Receive Notification	2725
☐ Surrogate Decision Making Data Form	2750

I am a duly authorized representative of the ICF/IID provider. To the best of my knowledge, the above information and statements are truthful and complete.

Printed Name	Title	Signature	Date

Day Phone Number with extension	Fax Number	Cell/Pager Number	Email Address (if applicable)

Facility Ownership Name	Address (Street, City, State, ZIP)

Send completed form to:
Surrogate Decision Making Program
Texas Department of Aging and Disability Services
Consumer Rights and Services
701 West 51st St.
Mail Code E-249
Austin, TX 78751

If you have questions or need assistance:
Call: 512-438-4275 / 512-438-4193 / 512-438-4573
Fax: 512-438-2883